The National Education, Health and Allied Workers' Union (NEHAWU) strikes

To the Editor: Articles by Dhai and Mahomed[1] and McQuoid-Mason[2] on the recent industrial unrest in North West Province (NWP) cover important aspects, including rights governing labour action, patients' rights and negotiation for essential services.

Over the past decade, we have lived through at least five NWP-wide strikes and numerous localised industrial actions. The larger strikes resulted in increased morbidity and mortality, particularly affecting disadvantaged sections of the community, who are totally dependent on public health services and powerless to choose other facilities for healthcare. The increased morbidity would have permanent sequelae, reducing life expectancy and quality of life – a realistic example is the unavailability of insulin or antihypertensives at clinics, resulting in well-described clinical complications and chronic disease progression.

The strikers made very legitimate demands and had valid reasons for strike action. These included drug, medical supply and staff shortages, problems with infrastructure, the use of poorly paid community health workers as 'slave labour', and blatant corruption in the procurement of goods and services.

The no-work-no-pay labour principle for strike action, despite the presence of attendance registers, was 'negotiated' off the table as part of return-to-work agreements between politicians and labour. To date, no one has been held accountable for the deaths, pain and suffering directly attributable to these strikes. The actions, responses and lack of leadership by the National Department of Health (NDoH) and NWP were equally responsible for the escalation of labour action, as well as denial of appropriate care. The phrase 'getting away with murder' has repeatedly been used by those affected, but none of the responsible entities has been held to account. Both the NDoH and strikers are equally responsible – one, the Department, an unnoticed killer, the other, the strikers, noticed when acute care was denied. How can a 'caring state' allow the removal of consequences to this 'murder'? Only according to the international laws of armed conflict is this permissible. Who also should be accountable for those deaths, which will be classified as 'natural' deaths, due to interruptions of provision of care and medications to patients with chronic diseases?

We argue that it is not possible to negotiate any minimum level of essential health services without directly incurring increases in morbidity and mortality. Existing health services are not sufficiently stable to make this adjustment. Organised labour is also not sufficiently disciplined and organised not to disrupt health service delivery. The responses by national government in the form of providing South African military health services were only partially effective as they were slow to muster, and the NDoH only acted after the strike had ended.

To accommodate both the right to strike and patients' rights, the following are recommended:

1. Strike action and picketing should be permitted, within the legal frameworks, only at health service administrative buildings and not at clinical facilities.
2. A team led by national government is to be immediately deployed at the onset of strike action to:
   - Assist management and labour to communicate effectively and address issues raised, to proactively minimise the need for industrial action
   - Facilitate and enforce consequence management of absenteeism and transgressions around strike action
   - Monitor and redress attributable mortality and morbidity
   - Assist with remedial post-strike measures.

Death and disability directly attributable to strike action on the scale seen in NWP are no less of a tragedy than Esidimeni and should be subject to similar judicial inquiry and processes, to allow for redress and to ensure that such circumstances never happen again.

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